

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-028767

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3989 STATE FILE NUMBER

FILED AUG 6 1963

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY Jackson  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY Jackson |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN Kansas City                  |  | c. CITY OR TOWN Kansas City  |  |
| Length of stay in 1b<br>8 years   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION St. Lukes Hospital |  | d. STREET ADDRESS (If outside, give location)<br>6532 Oak St.  |  |
| Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>              |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |  |

|   |                           |   |  |                              |  |
|---|---------------------------|---|--|------------------------------|--|
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br>CLARENCE A. WILLIAMS                                  |                           |   | 4. DATE OF DEATH<br>Month Day Year<br>July 15, 1963    |                              |  |
| 5. SEX<br>Male  | 6. COLOR OR RACE<br>White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br>Sept. 1, 1900                      | 9. AGE (last birthday)<br>62 | IF UNDER 1 YEAR<br>Months Days                               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Sales Dept.        |                           |   | 10b. KIND OF BUSINESS OR INDUSTRY<br>Phillips Pet. Co. |                              | 11. BIRTHPLACE (City and state or country)<br>Alva, Oklahoma |
| 12. CITIZEN OF WHAT COUNTRY<br>U.S.A.   |                           |   |  |                              |  |
| 13a. FATHER'S NAME<br>David H. Williams   |                           |   | 13b. MOTHER'S MAIDEN NAME<br>Flora Sloneker            |                              | 14. NAME OF HUSBAND OR WIFE<br>Laura Williams                |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br>No |                           |   | 16. SOCIAL SECURITY NO.<br>[Redacted]                  |                              | 17. INFORMANT<br>Mrs. Laura Williams 6532 Oak St.            |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Carcinoma of prostate</i> |  | INTERVAL BETWEEN ONSET AND DEATH<br>5 yrs.   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b)<br>DUE TO (c)                 |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)      |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

|  |   |  |   |
|--|---|--|---|
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |   |
| 20c. TIME OF INJURY<br>Hour a.m. p.m.  | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>    |  |   |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   | 20f. CITY, TOWN, OR LOCATION<br>COUNTY STATE   |   |
| 21. I attended the deceased from 1959 to July 15 '63 and last saw him live on July 14, '63<br>Death occurred at 3:05 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. |   |  |   |
| 22a. SIGNATURE<br>John B. Justus MD  |   | 22b. ADDRESS<br>4620 N. Nichols Pkwy E.C. 12, Mo   | 22c. DATE SIGNED<br>7-15-63                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Removal   | 23b. DATE<br>7-15-63  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Hope Cemetery                                      | 23d. LOCATION (City, town, or county) (State)<br>Topeka, Kansas |

|  |                             |   |  |
|--|-----------------------------|---|--|
| 24. FUNERAL DIRECTOR<br>Freeman Mortuary | ADDRESS<br>Kansas City, Mo. | 25. DATE RECD. BY LOCAL REG.<br>7-15-63 | 26. REGISTRAR'S SIGNATURE<br>Ruth Long |
|--|-----------------------------|---|--|

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

John B. Justus MEDICAL CERTIFICATION

Mr. John Justus  
4620 Windsor Plany  
Je. 1-1500

AUG 8 1963

# STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*J. H. Freeman*

Licensed Embalmer No.

2939

P. O. Address

*J. C. W. O.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.